		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0045203

Facility Name: GROSSE POINTE MANOR

Address: 6601 WEST TOUHY AVENUE (Number) NILES (City) 60714 (Zip Code)

County: COOK

Telephone Number: (847) 647-9875 **Fax #** (847) 588-0870

IDPA ID Number: 36-4411703001

Date of Initial License for Current Owners: 09/07/01

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) SHERRY MAUER
(Title) ADMINISTRATOR

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number GROSSE POINTE MANOR # 0045203 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	99	36,135	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			1,374	1,374	8
9	SNF/PED					9
10	ICF	10,579	6,680		17,259	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,579	6,680	1,374	18,633	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 51.56%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/01

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 01/01/01 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 47 and days of care provided 1,149

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number GROSSE POINTE MANOR # 0045203 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	198,493	8,451	3,605	210,549		210,549	0	210,549			1
2	Food Purchase		124,706		124,706	(33,325)	91,381	(2,113)	89,268			2
3	Housekeeping	101,544	17,109	0	118,653		118,653	0	118,653			3
4	Laundry	38,335	12,443	6,667	57,445		57,445	0	57,445			4
5	Heat and Other Utilities			92,279	92,279		92,279	341	92,620			5
6	Maintenance	32,382	46,615	12,830	91,827		91,827	1,770	93,597			6
7	Other (specify):*			10,582	10,582		10,582	366	10,948			7
8	**TOTAL General Services**	370,754	209,324	125,963	706,041	(33,325)	672,716	364	673,080			8
	B. Health Care and Programs											
9	Medical Director	0		4,000	4,000		4,000	0	4,000			9
10	Nursing and Medical Records	1,205,266	49,967	62,486	1,317,719		1,317,719	(71)	1,317,648			10
10a	Therapy	0	310	3,133	3,443		3,443	0	3,443			10a
11	Activities	76,606	3,915	1,974	82,495		82,495	0	82,495			11
12	Social Services	31,740		4,583	36,323		36,323	0	36,323			12
13	Nurse Aide Training			0	0		0	53	53			13
14	Program Transportation			665	665		665	0	665			14
15	Other (specify):*				0		0	0	0			15
16	**TOTAL Health Care and Programs**	1,313,612	54,192	76,841	1,444,645	0	1,444,645	(18)	1,444,627			16
	C. General Administration											
17	Administrative	81,130		0	81,130		81,130	17,654	98,784			17
18	Directors Fees			0	0		0	0	0			18
19	Professional Services			50,438	50,438		50,438	768	51,206			19
20	Dues, Fees, Subscriptions & Promotions			58,224	58,224		58,224	(50,294)	7,930			20
21	Clerical & General Office Expenses	65,461	21,538	38,548	125,547		125,547	7,030	132,577			21
22	Employee Benefits & Payroll Taxes			259,483	259,483	33,325	292,808	0	292,808			22
23	Inservice Training & Education			0	0		0	0	0			23
24	Travel and Seminar			465	465		465	381	846			24
25	Other Admin. Staff Transportation			0	0		0	48	48			25
26	Insurance-Prop.Liab.Malpractice			104,091	104,091		104,091	1,539	105,630			26
27	Other (specify):*			0	0		0	4,814	4,814			27
28	**TOTAL General Administration**	146,591	21,538	511,249	679,378	33,325	712,703	(18,060)	694,643			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,830,957	285,054	714,053	2,830,064	0	2,830,064	(17,714)	2,812,350			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number GROSSE POINTE MANOR #0045203 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			3,504	3,504		3,504	170,745	174,249			30
31	Amortization of Pre-Op. & Org.				0		0	0	0			31
32	Interest			42,783	42,783		42,783	361,985	404,768			32
33	Real Estate Taxes				0		0	805	805			33
34	Rent-Facility & Grounds			483,000	483,000		483,000	(483,000)	0			34
35	Rent-Equipment & Vehicles			8,763	8,763		8,763	3,294	12,057			35
36	Other (specify):* Vac/Sick Paid			(64,558)	(64,558)		(64,558)	0	(64,558)			36
37	**TOTAL Ownership**			473,492	473,492	0	473,492	53,829	527,321			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		32,244	30,818	63,062		63,062	(226)	62,836			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			54,203	54,203		54,203	0	54,203			42
43	Other (specify):*				0		0	0	0			43
44	**TOTAL Special Cost Centers**	0	32,244	85,021	117,265	0	117,265	(226)	117,039			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,830,957	317,298	1,272,566	3,420,821	0	3,420,821	35,889	3,456,710			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number GROSSE POINTE MANOR # 0045203 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(35,301)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(580)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,533)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(39)	21		18
19	Entertainment	0	20		19
20	Contributions	(410)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	0	27		24
25	Fund Raising, Advertising and Promotional	(50,351)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	0	20		28
29	Other-Attach Schedule	0			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (88,214)		$ 0	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	124,103		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 124,103		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 35,889		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

GROSSE POINTE MANOR

ID# 0045203

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 0	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number GROSSE POINTE MANOR # 0045203 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,113)	0	0	0	0	0	0	0	0	0	0	(2,113)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	341	0	0	0	0	0	0	0	0	341	5
6	Maintenance	0	0	1,770	0	0	0	0	0	0	0	0	1,770	6
7	Other (specify):*	0	0	366	0	0	0	0	0	0	0	0	366	7
8	**TOTAL General Services**	(2,113)	0	2,477	0	0	0	0	0	0	0	0	364	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	(71)	0	0	0	0	0	(71)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	53	0	0	0	0	0	0	0	0	53	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	53	0	0	(71)	0	0	0	0	0	(18)	16
	C. General Administration													
17	Administrative	0	0	0	17,654	0	0	0	0	0	0	0	17,654	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	768	0	0	0	0	0	0	0	0	768	19
20	Fees, Subscriptions & Promotions	(50,761)	0	467	0	0	0	0	0	0	0	0	(50,294)	20
21	Clerical & General Office Expenses	(39)	(14,000)	19,005	2,064	0	0	0	0	0	0	0	7,030	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	381	0	0	0	0	0	0	0	0	381	24
25	Other Admin. Staff Transportation	0	0	48	0	0	0	0	0	0	0	0	48	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,539	0	0	0	0	0	0	0	0	1,539	26
27	Other (specify):*	0	0	3,065	0	1,749	0	0	0	0	0	0	4,814	27
28	**TOTAL General Administration**	(50,800)	(14,000)	25,273	19,718	1,749	0	0	0	0	0	0	(18,060)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(52,913)	(14,000)	27,803	19,718	1,749	(71)	0	0	0	0	0	(17,714)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number GROSSE POINTE MANOR **#** 0045203 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(35,301)	204,598	1,448	0	0	0	0	0	0	0	0	170,745	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	361,157	828	0	0	0	0	0	0	0	0	361,985	32
33	Real Estate Taxes	0	0	805	0	0	0	0	0	0	0	0	805	33
34	Rent-Facility & Grounds	0	(483,000)	0	0	0	0	0	0	0	0	0	(483,000)	34
35	Rent-Equipment & Vehicles	0	0	3,294	0	0	0	0	0	0	0	0	3,294	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(35,301)	82,755	6,375	0	0	0	0	0	0	0	0	53,829	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	(226)	0	0	0	0	0	(226)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	(226)	0	0	0	0	0	(226)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(88,214)	68,755	34,178	19,718	1,749	(297)	0	0	0	0	0	35,889	45

Facility Name & ID Number GROSSE POINTE MANOR # 0045203 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		SCHEDULE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	BOOKKEEPING FEES	$ 14,000	DYNAMIC HEALTHCARE CONSULTANTS		$	$ (14,000)	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V	34	RENT	483,000	GROSS POINTE MANOR REALTY LLC			(483,000)	7
8	V	30	DEPRECIATION				204,598	204,598	8
9	V	32	INTEREST				361,157	361,157	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 497,000			$ 565,755	$ * 68,755	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GROSSE POINTE MANOR # 0045203 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		5	UTILITIES	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 341	$ 341	15
16	V		6	REPAIRS & MAINT.		" " "	100.00%	1,770	1,770	16
17	V		7	EMP. BEN. - GEN. SERVICES		" " "	100.00%	366	366	17
18	V		13	NURSES AIDE TRAINING		" " "	100.00%	53	53	18
19	V		19	PROFESSIONAL FEE		" " "	100.00%	768	768	19
20	V		20	DUES AND SUBSCRIPTION		" " "	100.00%	467	467	20
21	V		21	CLERICAL & GENERAL		" " "	100.00%	19,005	19,005	21
22	V		24	SEMINAR AND TRAVEL		" " "	100.00%	381	381	22
23	V		25	ADMIN STAFF TRANS		" " "	100.00%	48	48	23
24	V		26	INSURANCE		" " "	100.00%	1,539	1,539	24
25	V		27	EMP. BEN. - GEN. ADMIN		" " "	100.00%	3,065	3,065	25
26	V		30	DEPRECIATION		" " "	100.00%	1,448	1,448	26
27	V		32	INTEREST		" " "	100.00%	828	828	27
28	V		33	REAL ESTATE TAXES		" " "	100.00%	805	805	28
29	V		35	EQUIPMENT RENTAL		" " "	100.00%	3,294	3,294	29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$ 34,178	$ * 34,178	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GROSSE POINTE MANOR # 0045203 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		6	MAINT. CMP. - D. NEHMER	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$	$	15
16	V		10	NURSING CMP - SUE G.		" " "	100.00%			16
17	V		17	ADMIN. CMP. - M. MAUER		" " "	100.00%	13,061	13,061	17
18	V		17	ADMIN. CMP. - M. AARON		" " "	100.00%			18
19	V		17	ADMIN. CMP. - F. AARON		" " "	100.00%			19
20	V		17	ADMIN. CMP. - S. GOLDSTEIN		" " "	100.00%			20
21	V		17	ADMIN. CMP. - S. KOPLIN		" " "	100.00%			21
22	V		17	ADMIN. CMP. - D. MAGAFAS		" " "	100.00%			22
23	V		17	ADMIN. CMP. - E. CASSON		" " "	100.00%			23
24	V		17	ADMIN. CMP. - S. BOGEN		" " "	100.00%			24
25	V		17	ADMIN. CMP. - S. LEVY		" " "	100.00%	4,593	4,593	25
26	V		17	ADMIN. CMP. - HOWARD ALTER		" " "	100.00%			26
27	V		17	ADMIN. CMP. - NON-OWNER		" " "	100.00%			27
28	V		21	ADMIN. CMP. - S. AARON		" " "	100.00%	2,064	2,064	28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$ 19,718	$ * 19,718	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number GROSSE POINTE MANOR # 0045203 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	7	EMP. BEN. - D. NEHMER	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$	$	15
16	V	15	EMP. BEN. - SUE G.		" " "	100.00%			16
17	V	27	EMP. BEN. - M. MAUER		" " "	100.00%	834	834	17
18	V	27	EMP. BEN. - M. AARON		" " "	100.00%			18
19	V	27	EMP. BEN. - F. AARON		" " "	100.00%			19
20	V	27	EMP. BEN. - S. GOLDSTEIN		" " "	100.00%			20
21	V	27	EMP. BEN. - S. KOPLIN		" " "	100.00%			21
22	V	27	EMP. BEN. - D. MAGAFAS		" " "	100.00%			22
23	V	27	EMP. BEN. - E. CASSON		" " "	100.00%			23
24	V	27	EMP. BEN. - S. BOGEN		" " "	100.00%			24
25	V	27	EMP. BEN. - S. LEVY		" " "	100.00%	638	638	25
26	V	27	EMP. BEN. - HOWARD ALTER		" " "	100.00%			26
27	V	27	EMP. BEN. - NON-OWNER		" " "	100.00%			27
28	V	27	EMP. BEN. - S. AARON		" " "	100.00%	277	277	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 1,749	$ * 1,749	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number GROSSE POINTE MANOR # 0045203 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10a	THERAPHY	$	DYNAMIC REHAB CONSULTANTS LLC		$	$	15
16	V	22	EMPLOYEE BENEFITS		" " "				16
17	V	39	ANCILLARY SERVICES		" " "				17
18	V								18
19	V								19
20	V	10	NURSING & MEDICAL SUPP		PHARMCOR LLC				20
21	V	11	ACTIVITIES		" "				21
22	V	22	EMPLOYEE BENEFITS		" "				22
23	V	39	ANCILLARY EXPENSE		" "				23
24	V								24
25	V								25
26	V								26
27	V	10	MEDICAL SUPPLIES	345	LINCOLN MEDICAL SUPPLIES, INC.		274	(71)	27
28	V	39	ANCILLARY EXPENSE	1,094	" " "		868	(226)	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,439			$ 1,142	$ * (297)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number GROSSE POINTE MANOR # 0045203 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	SHERRY MAUER		ADMINISTRATIVE		SCHEDULE ATTACHED			SALARY	$ 81,130	17-3	1
2	MARSHALL MAUER		ADMINISTRATIVE					SALARY	13,061	17-7	2
3	SHARON AARON		CLERICAL					SALARY	2,064	21-7	3
4	DOVIE MAUER		FILE CLERK	0.00				SALARY	1,885	21-1	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 98,140		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number GROSSE POINTE MANOR # 0045203 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONSULTANTS
Street Address: 3359 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	TOTAL PATIENT DAYS	577,359	13	$ 10,580	$	18,633	$ 341	1
2	6	REPAIRS & MAINT	" "	577,359	13	54,834	37,633	18,633	1,770	2
3	7	EMP. BEN. - GEN. SVC.	" "	577,359	13	11,326		18,633	366	3
4	13	NURSES AIDE TRAINING	" "	577,359	13	1,650		18,633	53	4
5	19	PROFESSIONAL FEES	" "	577,359	13	23,811		18,633	768	5
6	20	DUES & SUBSCRIPTION	" "	577,359	13	14,469		18,633	467	6
7	21	CLERICAL & GENERAL	" "	577,359	13	588,891	487,646	18,633	19,005	7
8	24	SEMINAR & TRAVEL	" "	577,359	13	11,803		18,633	381	8
9	25	ADMIN. STAFF TRANS.	" "	577,359	13	1,502		18,633	48	9
10	26	INSURANCE	" "	577,359	13	47,685		18,633	1,539	10
11	27	EMP. BEN. - GEN. ADMIN	" "	577,359	13	94,969		18,633	3,065	11
12	30	DEPRECIATION	" "	577,359	13	44,866		18,633	1,448	12
13	32	INTEREST	" "	577,359	13	25,667		18,633	828	13
14	33	REAL ESTATE TAXES	" "	577,359	13	24,936		18,633	805	14
15	35	EQUIPMENT RENTAL	" "	577,359	13	102,054		18,633	3,294	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,059,043	$ 525,279		$ 34,178	25

Facility Name & ID Number GROSSE POINTE MANOR # 0045203 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

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	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINT. CMP. - D. NEHMER	WGHTD. AVG. HOUR	40	12	$ 62,194	$ 62,194		$ 0	1
2	10	NURSING - SUE G.	" "	40	1	45,894	45,894		0	2
3	17	ADMIN. CMP. - M. MAUER	" "	40	13	398,821	398,821	1	13,061	3
4	17	ADMIN. CMP. - M. AARON	" "	45	12	521,536	521,536		0	4
5	17	ADMIN. CMP. - F. AARON	" "	45	6	191,700	191,700		0	5
6	17	ADMIN. CMP. - S. GOLDSTEIN	" "	50	3	161,003	161,003		0	6
7	17	ADMIN. CMP. - S. KOPLIN	" "	45	8	71,993	71,993		0	7
8	17	ADMIN. CMP. - D. MAGAPAS	" "	45	8	81,938	81,938		0	8
9	17	ADMIN. CMP. - E. CASSON	" "	38	1	47,846	47,846		0	9
10	17	ADMIN. CMP. - S. BOGEN	" "	45	3	96,858	96,858		0	10
11	17	ADMIN. CMP. - S. LEVY	" "	55	13	139,807	139,807	2	4,593	11
12	17	ADMIN. CMP. - H. ALTER	" "	40	1	9,000	9,000		0	12
13	17	ADMIN. CMP. - NON-OWNER	" "	45	13	219,069	219,069		0	13
14	21	CLERICAL CMP. - S. AARON	" "	40	13	63,022	63,022	1	2,064	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,110,681	$ 2,110,681		$ 19,718	25

Facility Name & ID Number GROSSE POINTE MANOR # 0045203 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

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	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	7	EMP BEN - D. NEHMER	WGHTD. AVG. HOURS	40	12	$ 4,545	$		$ 0	1
2	15	EMP BEN - SUE G.	" "	40	1	3,924			0	2
3	27	EMP BEN - M. MAUER	" "	40	13	25,461		1	834	3
4	27	EMP BEN - M. AARON	" "	45	12	35,957			0	4
5	27	EMP BEN - F. AARON	" "	45	6	22,028			0	5
6	27	EMP BEN - S. GOLDSTEIN	" "	50	3	20,193			0	6
7	27	EMP BEN - S. KOPLIN	" "	45	8	16,504			0	7
8	27	EMP BEN - D. MAGAFAS	" "	45	8	17,632			0	8
9	27	EMP BEN - E. CASSON	" "	38	1	11,976			0	9
10	27	EMP BEN - S. BOGEN	" "	45	3	6,849			0	10
11	27	EMP BEN - S. LEVY	" "	55	13	19,408		2	638	11
12	27	EMP BEN - H. ALTER	" "	40	1	1,068			0	12
13	27	EMP BEN - NON-OWNER	" "	45	13	29,449			0	13
14	27	EMP BEN - S. AARON	" "	40	13	8,457		1	277	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 223,451	$		$ 1,749	25

Facility Name & ID Number GROSSE POINTE MANOR # 0045203 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONSULTANTS
Street Address: 3359 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
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Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		DYNAMIC REHAB CONSULTANTS				$	$		$	1
2	10a	THERAPHY	DIRECT ALLOCATION							2
3	22	EMPLOYEE BENEFITS	" "							3
4	39	ANCILLARY SERVICES	" "							4
5										5
6										6
7		PHARCOR LLC								7
8	10	NURSING & MEDICAL SUPPLY	DIRECT ALLOCATION							8
9	22	EMPLOYEE BENEFITS	" "							9
10	39	ANCILLARY EXPENSE	" "							10
11										11
12										12
13										13
14		LINCOLN MEDICAL SUPPLIES								14
15	10	MEDICAL SUPPLIES	DIRECT ALLOCATION						274	15
16	39	ANCILLARY EXPENSE	" "						868	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 1,142	25

Facility Name & ID Number GROSSE POINTE MANOR # 0045203 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	MANUFACTURERS BANK		X	MORTGAGE			$ 5,000,000	$ 4,935,981			$ 361,157	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MANUFACTURERS BANK		X	LINE OF CREDIT				1,249,938		PRIME+	42,783	6
7												7
8	RELATED PARTY	X									828	8
9	TOTAL Facility Related						$ 5,000,000	$ 6,185,919			$ 404,768	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 0	14
15	TOTALS (line 9+line14)						$ 5,000,000	$ 6,185,919			$ 404,768	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number GROSSE POINTE MANOR # 0045203 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 0	2
3. Under or (over) accrual (line 2 minus line 1).		$ 0	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 0	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 0	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1996	8
	1997	9
	1998	10
	1999	11
	2000	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2000 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME GROSSE POINTE MANOR COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0045203

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 0.00	$ 0.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number GROSSE POINTE MANOR # 0045203 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		2001	$ 573,648	1
2					2
3	TOTALS			$ 573,648	3

Facility Name & ID Number GROSSE POINTE MANOR # 0045203 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			2001		$ 3,862,200	$ 134,598	27.5	$ 134,598	$	$ 134,598	4
5											5
6											6
7											7
8					14,316	367	35	409	42	3,409	8
	Improvement Type**										
9	ICE MACHINE DRAIN/COOLING PUMP/WATER PUMP			2001	10,464	220	27.5	220		220	9
10	ROOFING			2001	34,800	433	27.5	433		433	10
11	SURVEILLANCE EQUIP/ANTENNA			2001	2,250	58	27.5	58		58	11
12	TELEPHONE/SPLITTERS			2001	4,209	602	7	602		602	12
13	DINING CAR/ROOM SIGNS			2001	8,744	65	27.5	65		65	13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number GROSSE POINTE MANOR # 0045203 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,936,983	$ 136,343		$ 136,385	$ 42	$ 139,385	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GROSSE POINTE MANOR # 0045203 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$	$	$	$ 0		$	71
72	Current Year Purchases	14,456	2,126	1,445	(681)	10	1,445	72
73	Fully Depreciated Assets				0			73
74	RELATED PARTY	358,502	70,982	35,850	(35,132)	10	35,850	74
75	TOTALS	$ 372,958	$ 73,108	$ 37,295	$ (35,813)		$ 37,295	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$ 1,817	$ 99	$ 569	$ 470		$ 655	76
77							0			77
78							0			78
79							0			79
80	TOTALS			$ 1,817	$ 99	$ 569	$ 470		$ 655	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,885,406	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 209,550	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 174,249	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (35,301)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 177,335	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92			92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NA
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
    Beginning ____
    Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 8,763 Description: SEE SCHEDULE ATTACHED
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number GROSSE POINTE MANOR # 0045203 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? ☐ YES ☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - COMMUNITY COLLEGE ☐
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	Nurse Aide Competency Tests		53		53
9	TOTALS	$ 0	$ 53	$ 0	$ 53
10	SUM OF line 9, col. 1 and 2 (e)	$ 53			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$ 9,768	$		$ 9,768	1
2	Licensed Speech and Language Development Therapist		hrs			1,782			1,782	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			16,468			16,468	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				29,173		29,173	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): LAB, MED SUPPLIES						5,871		5,871	13
14	TOTAL			$		$ 28,018	$ 35,044		$ 63,062	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number GROSSE POINTE MANOR **#** 0045203 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2001 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 124,035	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	519,003		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	29,131		6
7	Other Prepaid Expenses	1,409		7
8	Accounts Receivable (owners or related parties)	32,886		8
9	Other(specify): SECURITY DEPOSIT	300		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 706,764	$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	60,467		15
16	Equipment, at Historical Cost	14,456		16
17	Accumulated Depreciation (book methods)	(3,504)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 71,419	$ 0	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 778,183	$ 0	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 292,348	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,249,938		29
30	Accrued Salaries Payable	134,770		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,774		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	5,608		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,687,438	$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 0	$ 0	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,687,438	$ 0	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (909,255)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 778,183	$ 0	48

***(See instructions.)**

Facility Name & ID Number GROSSE POINTE MANOR # 0045203 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 0	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(919,255)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock	10,000	9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (909,255)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (909,255)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number GROSSE POINTE MANOR # 0045203 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,482,320	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,482,320	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	18,666	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 18,666	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 0	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DISCOUNT	493	28
28a	VENDING COMMISSION	87	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 580	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,501,566	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	706,041	31
32	Health Care	1,444,645	32
33	General Administration	679,378	33
	B. Capital Expense		
34	Ownership	473,492	34
	C. Ancillary Expense		
35	Special Cost Centers	63,062	35
36	Provider Participation Fee	54,203	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,420,821	40
41	**Income before Income Taxes (line 30 minus line 40)****	(919,255)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (919,255)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number GROSSE POINTE MANOR # 0045203 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,464	1,624	$ 45,655	$ 28.11	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,213	12,186	285,032	23.39	3
4	Licensed Practical Nurses	8,994	10,427	208,897	20.03	4
5	Nurse Aides & Orderlies	44,693	49,811	648,693	13.02	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,981	3,135	34,952	11.15	9
10	Activity Assistants	4,081	5,027	41,654	8.29	10
11	Social Service Workers	1,720	1,852	31,740	17.14	11
12	Dietician					12
13	Food Service Supervisor	1,898	2,385	32,017	13.42	13
14	Head Cook	1,815	2,484	31,653	12.74	14
15	Cook Helpers/Assistants	6,738	8,241	77,575	9.41	15
16	Dishwashers	7,472	7,655	57,248	7.48	16
17	Maintenance Workers	1,474	1,611	32,382	20.10	17
18	Housekeepers	8,247	10,119	101,544	10.03	18
19	Laundry	3,213	3,993	38,335	9.60	19
20	Administrator	2,086	2,278	81,130	35.61	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,354	4,847	65,461	13.51	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,247	1,280	16,989	13.27	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	111,690	128,955	$ 1,830,957 *	$ 14.20	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 3,605	1-3	35
36	Medical Director	O	4,000	9-3	36
37	Medical Records Consultant	N	2,043	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	1,620	10-3	39
40	Physical Therapy Consultant	L	1,271	10a-3	40
41	Occupational Therapy Consultant	Y	1,676	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	186	10a-3	43
44	Activity Consultant	E	1,974	11-3	44
45	Social Service Consultant	E	1,958	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 18,333		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	1,256	45,226	10-3	51
52	Nurse Aides	618	13,597	10-3	52
53	TOTAL (lines 50 - 52)	1,874	$ 58,823		53

Facility Name & ID Number GROSSE POINTE MANOR # 0045203 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
SHERRY MAUER	ADMIN	22.3	$ 81,130
			0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 81,130

B. Administrative - Other

Description	Amount
	$ 0
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
MID AMERICA PROGRAM	DATA PROCESSING	$ 1,350
HEALTH DATA SYSTEM	DATA PROCESSING	3,935
KRUPNICK, BOKOR, KAGDA	ACCOUNTING	14,250
FROST RUTTENBERG	ACCOUNTING	21,283
PERSONAL PLANNERS	UC CONSULTANT	540
J. LOTT ASSOC		500
SACHNOFF & WEAVER	LEGAL	2,083
LANER, MUCHIN	LEGAL	6,497
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 50,438

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 29,554
Unemployment Compensation Insurance	10,747
FICA Taxes	132,345
Employee Health Insurance	83,899
Employee Meals	33,325
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	2,938
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	0
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 292,808

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	3,998
Health Care Worker Background Check	70
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	50,351
RELATED PARTY	467
CONTRIBUTIONS	410
DUES & SUBSCRIPTIONS	364
LICENSES & PERMITS	2,831
LESS CONTRIBUTIONS	(410)
Less: Public Relations Expense	(0)
Non-allowable advertising	(50,351)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,930

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	465
RELATED PARTY	381
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 846

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number GROSSE POINTE MANOR # 0045203 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number GROSSE POINTE MANOR # 0045203 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 14,326 Line 10-2

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 54,203
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 33,325 Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: GROSSE POINTE MANOR **#0045203** **Report Period Beginning: 01/01/2001** **Ending: 12/31/2001**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	3,605	
	REPAIRS & MAINTENANCE		0	
			0	3,605
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		2,308	
	OUTSIDE LABOR		4,359	6,667
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		25,384	
	ELECTRICITY		48,068	
	WATER		18,827	
	CABLE TV - LOBBY		0	
			0	92,279
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		55	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		4,033	
	ELEVATOR MAINTENANCE & REPAIR		6,102	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		2,640	
	FIRE SERVICE		0	
			0	
			0	
			0	12,830
7	**OTHER**			
	SCAVENGER		10,582	
	SECURITY SERVICE		0	10,582
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	4,000	4,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	58,823	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	2,043	
	PHARMACY CONSULTANT	XVIII B 39-2	1,620	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	62,486
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	1,271	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	1,676	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	186	3,133
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	1,974	
			0	1,974
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	1,958	
	CLERGY		2,625	4,583
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number GROSSE POINTE MANOR **#0045203** **Report Period Beginning: 01/01/2001** **Ending: 12/31/2001**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		665	665
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	0	0
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	5,285	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	45,153	
			0	50,438
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	50,351	
	EMPLOYEE WANT ADS	XIX F	3,998	
	CONTRIBUTIONS	VI 20 XIX F	310	
	DUES & SUBSCRIPTIONS	XIX F	364	
	LICENSES & PERMITS	XIX F	3,031	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	100	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	70	58,224
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES		1,955	
	EQUIPMENT REPAIR & MAINTENANCE		798	
	OUTSIDE CLERICAL SERVICES		14,000	
	PENALTIES / OVERDRAFT CHARGES	VI 18	39	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		21,756	
	MESSENGER SERVICE		0	
			0	38,548

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	132,345	
	UNEMPLOYMENT COMPENSATION	XIX D	10,747	
	WORKERS COMPENSATION INSURANC	XIX D	29,554	
	HOSPITALIZATION INSURANCE	XIX D	83,899	
	EMPLOYEE BENEFITS - OTHER	XIX D	2,938	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	259,483
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	465	
	TRAVEL	XIX G	0	
			0	
			0	465
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		0	0
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		104,091	104,091
27	**OTHER**			
	BAD DEBTS	VI 24	0	
			0	0

GRAND TOTAL COLUMN 3 OTHER 714,053

GROSSE POINTE MANOR
EMPLOYEE MEAL RECLASSIFICATION
12/31/2001

TOTAL FOOD PURCHASE	124,706
LESS SALES TAX	(1,533)
NET FOOD	126239
TOTAL PATIENT CENSUS	18,633
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	55899
ADD # EMPLOYEE MEALS/DAY	55
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	20075

PATIENT MEALS	55899
ADD EMPLOYEE MEALS	20075
TOTAL MEALS/YEAR	75974
NET FOOD	126239
DIVIDE TOTAL MEALS/YEAR	75974
COST PER MEAL	1.66
TIME EMPLOYEE MEALS	20075
EMPLOYEE MEAL RECLASSIFICATION	33325